

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County CharlesCity or town Comfest Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Charity Ann Brown

## 3. (b) Social Security Number

4. Sex F5. Color or race C6. (a) Single, married, widowed, or divorced W.6. (b) Name of husband or wife Charles H. Brown7. Birth date of deceased (mo., day, yr.) March 20, 1857

8. (c) If alive, give age..... years

8. AGE: Years 88 Months 2 Days 10

If less than one day..... hrs. .... min.

9. Birthplace Charles Co., Md.

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name Peace Bivens

15. Birthplace.....

16. Informant Jayes F. BrownAddress La Plata, Md.17. Burial Date thereof June 2, 1945

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Joseph'sLocation Pamper, Md.18. Funeral director Penny & CokerAddress Madison Springs, Md.19. June 1 1945 Jubie H. Carey

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 1945, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-10 1945 to 5-30 1945and that I last saw him/her alive on 5-30 1945Immediate cause of death Congestive Heart Failure

DURATION

Due to Bronchial Pneumonia 5-28-45

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

23. SIGNATURE E. Edelen M.D.Address La Plata Md Date signed 6-1-45

RECEIVED  
JUN 4 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 152

## CERTIFICATE OF DEATH

Reg. Dist. No. 104

## 1. PLACE OF DEATH:

County..... Charles  
 City or town..... Wayside  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Just birth  
 Hospital, institution, or street address where death occurred:  
Wayside, Md  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Charles  
 City or town..... Wayside  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Catherine Lavers Dorsey

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Single  
 6.(b) Name of husband or wife..... none  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... May 6, 1945  
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace..... Wayside-Charles  
 (Town, county and state)

10. Usual occupation.....

## 11. Industry or business

FATHER 12. Name..... Joseph Preston Dorsey  
 13. Birthplace..... Wayside, Md  
 MOTHER 14. Maiden name..... Catherine May Eddles  
 15. Birthplace..... Tomphinsville, Md

16. Informant.....  
 Address.....

17. Burial Date thereof..... 5/8/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Private Cemetery

Location..... Newport, Md

18. Funeral director..... Joseph Preston Dorsey

Address..... Wayside Md

19. 5/8 19 45 William H. Hap  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5/8 19 45, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from childbirth to the last post 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Unknown (Pneumonia) DURATION.....

away in sleep

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... William H. Hap M. D. or other

Address..... Tomphinsville, Md Date signed 5/8/45

RECEIVED  
MAY 11 1945  
BUREAU T. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 103

1. PLACE OF DEATH:  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....  
 5. Color or race.....  
 6. (a) Single; married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....  
 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days.....  
 If less than one day..... hrs..... min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereof.....

(Burial, cremation, or removal, Which?)..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 5-38-41.....

(Date rec'd by registrar)

19.....

Registrar

Address.....

Date signed.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-25-45, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw him..... alive on.....

Immediate cause of death.....  
 Due to.....

Due to.....  
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

RECEIVED  
JUL 6 1945  
BUREAU V.S.

RECEIVED  
JUL 6 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

04943

Reg. Dist. No. 106

## 1. PLACE OF DEATH:

County Charles  
 City or town Indian Head  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 36 hrs.  
 Hospital, institution, or street address where death occurred:  
-  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Charles  
 City or town Faulkner  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. -  
 (If rural, give LOCATION)  
 2(a) If veteran, name war -

## 3. (a) FULL NAME

Ballenger S. Goldsmith

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Elise Bauman Goldsmith  
 6. (c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) Nov. 28, 1884  
 8. AGE: Years 60 Months 4 Days 3 If less than one day - hrs. - min.

9. Birthplace St. Mary's County, Md.  
 (Town, county, and state)  
 10. Usual occupation General Hauling  
 11. Industry or business -

FATHER 12. Name Robert Goldsmith  
 13. Birthplace Beantown, Charles Co., Md.  
 MOTHER 14. Maiden name Anna Hill  
 15. Birthplace Mechanicsville, St. Marys Co. Md.

16. Informant Mr. B. S. Goldsmith  
 Address Faulkner, Md.

17. Burial Date thereof 5-4-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Ignace  
 Location Belairton md

18. Funeral director Smith & Ryan  
 Address Waldorf md

19. May 2 19 45 M. I. MD  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 45 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on May 1, 1945 to 1945 and that I last saw him on May 1, 1945

Immediate cause of death Coronary thrombosis DURATION 5-8 min.

Due to Coronary artery disease 8 yrs.

Due to Essential hypertension 8 yrs.

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE John E. Mackenzie, M.D. M. D. or otherAddress Faulkner, Md. Date signed 5-1-45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
MAY 7 1945  
BUREAU V.S.

OPTIONAL FORM NO. 10-45 (REV. 1-25-45)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

04944

Reg. Dist. No. 101

## 1. PLACE OF DEATH:

County... CharlesCity or town... Wellcome Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

at home

How long in hospital or institution?

## 3. (a) FULL NAME

GertrudeDorothy Proctor (changed J.F. 7/19/46 per J.F.S.)

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 20 1926

6. (c) If alive, give age... years

8. AGE:

18

Years

Months

7

Days

If less than one day

hrs.

min.

9. Birthplace

Belton, Md  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Clement Proctor

13. Birthplace

Belton, Md

MOTHER

14. Maiden name

Alberta Hally

15. Birthplace

White Plains, Md

16. Informant

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof May 14 1945  
(month) (day) (year)

Cemetery or crematory

St Thomas

Location

Belton, Md

18. Funeral director

Hunt & Ryan

Address

Waldorf, Md

19.

May 13 45  
(Date rec'd by registrar)Mrs. B. P. Bowie  
Regist. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Charles

City or town

Rural - Wellcome

(If outside city or town limits, write RURAL and give nearest town)

Street No.

 Cedar Pt. Neck

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 1219 45 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from on

May 1219 45 to19 45

and that I saw him on

May 1219 45

Immediate cause of death

Cerebral hemorrhage

Due to

Congenital cerebral aneurysm

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

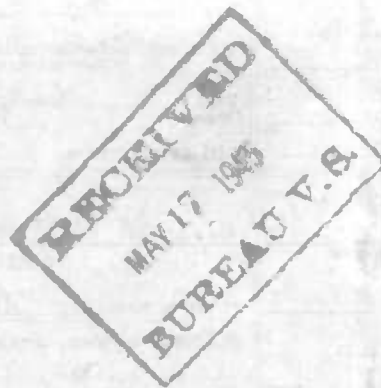
23. SIGNATURE

J. M. McKenney, M.D.  
Sup. Med. Examiner

M. D. or other

Address

La Plata, MdDate signed 5-12-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 700

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Physician Remiel Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

George Thomas

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Negro</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
8. (b) Name of husband or wife <u>Inez (Brown) Thomas</u>			
7. Birth date of deceased (mo., day, yr.) <u>Aug. 29 - 1914</u>			
8. AGE: Years <u>30</u> Months <u>8</u> Days <u>8</u> If less than one day hrs. min.			
9. Birthplace <u>Washington, D.C.</u> (Town, county, and state)			
10. Usual occupation <u>Attendant</u>			
11. Industry or business <u>Naval Powder Fcty.</u>			
12. Name <u>James Thomas</u>			
13. Birthplace <u>Chas. Co. Md</u>			
14. Maiden name <u>Rose Butler</u>			
15. Birthplace <u>Washington, D.C.</u>			
16. Informant <u>James Thomas</u> Address <u>La Plata, Md</u>			
17. <u>Burial</u> Date thereof <u>5-11-45</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>St Ignace</u> Location <u>Bel Air rd</u> <u>Shrout &amp; Rymer</u> 18. Funeral director <u>Macdoug rd</u> Address			
19. <u>5-10</u> 19 <u>45</u> (Date rec'd by registrar) Registrar <u>John H. Perry</u>			

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 45 at 1:43 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased on  
May 7 19 45 and that I last saw him on May 7 19 45  
 Immediate cause of death  
Pulmonary hemorrhage  
and edema  
 Due to Crushed chest  
 Due to Automobile accident  
 Other conditions Fractured 1st femur  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## DURATION

12 hr.12 hr.12 hr.12 hr.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-7-45  
 Where did injury occur? La Plata, Charles Pa  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where)? State Highway  
 Means of injury auto hit truck Injured at work? No  
 23. SIGNATURE John H. Perry Dep. Med. Examiner  
 Address La Plata, Pa M. D. or other  
 Date signed 5-7-45

RECEIVED

MAY 12 1945

BUREAU V.S.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore (92-8)

# CERTIFICATE OF DEATH

04946

Reg. Diat. No. 100

<b>1. PLACE OF DEATH:</b> County... <u>Cherokee</u> City or town... <u>Hwyville</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> How long in above place of death?... <u>Life</u> Hospital, institution, or street address where death occurred:  How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> <small>(For newborn infants give residence of mother)</small> State... <u>Mo</u> County... <u>Chester</u> City or town... <u>Hwyville</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> Street No..... <small>(If rural, give LOCATION)</small> 2(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Mary Elizabeth Wade</u>				<b>3. (b) Social Security Number</b> <u>none</u>			
<b>4. Sex</b> <u>F</u>		<b>5. Color or race</b> <u>Cal</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>			
<b>6. (b) Name of husband or wife</b> <u>Joseph Wade</u>				<b>6. (c) If alive, give age</b> <u>64</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Jan 29 1886</u>							
<b>8. AGE:</b> Years <u>5-9</u> Months <u>3</u> Days <u>14</u> If less than one day _____ hrs. _____ min.							
<b>9. Birthplace.</b> <u>Char Co</u> <small>(Town, county, and state)</small>							
<b>10. Usual occupation.</b> <u>House Wife</u>							
<b>11. Industry or business</b>							
<b>FATHER</b>							
<b>12. Name</b> <u>Samuel Sewell</u>							
<b>13. Birthplace</b> <u>Char Co Mo</u>							
<b>MOTHER</b>							
<b>14. Maiden name</b> <u>Mary L. Hall</u>							
<b>15. Birthplace</b> <u>Char Co</u>							
<b>16. Informant</b> <u>Joseph Wade</u> Address <u>Hwyville</u>							
<b>17. Burial</b> <small>(Burial, cremation, or removal. Which?)</small> <u>Burial</u> Date thereof <u>May 15 1945</u> <small>(month) (day) (year)</small> Cemetery or crematory <u>Lt Mary</u> Location <u>Bryantowne</u> <b>18. Funeral director</b> <u>Shirley M. Ponder</u> Address <u>Hwyville Mo</u>							
<b>19. Registrar</b> <u>J. H. Ponder</u> <small>(Date rec'd by registrar)</small> <u>5-15-45</u>							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>May 12</u> 19 <u>45</u> at <u>2:30 P.M.</u>							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>May 7</u> 19 <u>45</u> , to <u>May 12</u> 19 <u>45</u> and that I last saw him/her alive on <u>May 12</u> 19 <u>45</u>							
<b>Immediate cause of death</b> <u>Hypertension complicated by coronary artery disease</u>							
<b>Due to</b> <u>Myocardial infarction</u>							
<b>Due to</b> <u>No further information was obtained</u> <u>by Dr. J. H. Ponder</u>							
<b>Other conditions</b> <u>Nephritis</u>							
<small>(Include pregnancy within 3 months of death)</small>							
<b>Major findings of operations</b>							
Date of op. ....							
<b>Autopsy results</b>							
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:							
Accident, suicide, or homicide..... Date of .....							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?) .....							
Means of Injury ..... Injured at work?							
<b>23. SIGNATURE</b> <u>Levin J. Oshorn</u> M. D. or other							
Address <u>Chester Mo</u> Date signed <u>5/13/45</u>							

RECEIVED

MAY 18 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County LaPlata Md.City or town LaPlata Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3-26-45 Life

Hospital, institution, or street address where death occurred:

Phys. Mem. Hosp. LaPlata Md.How long in hospital or institution? 3-26-45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County ChasCity or town LaPlata Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Winston Killett

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S6. (b) Name of husband or wife -7. Birth date of deceased (mo., day, yr.) 10-1-24 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 20 Months 7 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Charles Co Md.  
(Town, county, and state)10. Usual occupation Student

11. Industry or business \_\_\_\_\_

FATHER 12. Name Burgie B. Killett  
13. Birthplace Waldorf MdMOTHER 14. Maiden name Edna Bruceella Pierced  
15. Birthplace Waldorf Md16. Informant Burgie B. Killett  
Address Waldorf Md17. Burial (Burial, cremation, or removal. Which) Burial Date thereof May 22-45  
(month) (day) (year)Cemetery or crematory St PaulsLocation Finney Mr Waldorf Md18. Funeral director Thomas A. BrownAddress Waldorf Md19. May 22 19. 45 John H. Passy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 19. 45 at 1 PM M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-26 19. 45, to 5-19 19. 45.  
and that I last saw him alive on 5-19 19. 45

Immediate cause of death \_\_\_\_\_

DURATION

Peritonitis4-3-45Due to appendicitis3-26-45

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Sub-acute appendicitis  
Date of op. 3-27-45

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. Edeen M. J  
Address LaPlata Md M. D. or other \_\_\_\_\_  
Date signed 5-26-45

RECEIVED  
MAY 25 1945  
BUREAU V.B.